

Governor Dave Freudenthal

WYOMING DEPARTMENT OF HEALTH OFFICE OF EMERGENCY MEDICAL SERVICES TRAUMA PROGRAM UNCOMPENSATED TRAUMA CARE REIMBURSEMENT FORM

This form must be used when submitting a request for reimbursement for uncompensated trauma care. Incomplete forms will not be accepted and will be returned to the hospital trauma coordinator or ambulance service director. Additional forms are available, at no cost, from the Department of Health's Office of Emergency Medical Services. Phone: 1-307-777-7955 or in-state toll-free: 1-888-228-8996.

The Wyoming Legislature set aside monies for uncompensated trauma care for the biennium. This money is being divided for disbursement into four quarters. No single hospital or ambulance service may receive more than twenty five percent (25%) of the monies allotted per quarter. This form is for the third quarter of disbursement. Copies of the form may be used for submissions.

Claims for this quarter must be filed with this office by September 15, 2010. Anything arriving in this office after this date, will be denied. Disbursements will be made by the end of September 2010.

This quarter's money is for patients that were cared for from July 1, 2009, through December 31, 2009.

In order for reimbursement, a claim for a patient needs to meet the following:

- 1. Patient meets the criteria for entry into the trauma registry:
- 2. Completion of a full collection process, as currently required by Medicare, for Medicare baddebt reimbursement, has been done; **and**
- 3. The hospital's trauma registry data submission must be current with the EMS Office.



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Se	ction A: Facility/ Ambulance Service Patient Information				
1.	Name and mailing address of hospital or ambulance service where the services were rendered: Facility or Service Name: Street Address/P.O. Box: City, State, Zip:				
2.	Patient's hospital record number:				
3.	17-Digit Trauma Registry Number:				
1.	Patient was: (check one): Hospital:				
	☐ Admitted from this hospital's Emergency Department.				
	☐ Transferred from another facility and seen in this hospital's Emergency Department. Transferred from:				
	☐ Interfacility transfer, direct admit, not seen in this hospital's Emergency Department . Transferred from:				
	☐ Seen in this hospital's Emergency Department; transferred to:				
	Admitting physician (please type or print):				
	Referring physician (if applicable, please type or print):				
	Dates of Service: From MM/DD/YY to MM/DD/YY:				
	Are medical services continuing? (Check one) Yes				

Office of Emergency Medical Services Hathaway Building, 4^{th} Floor · Cheyenne WY 82002 FAX (307) 777-5639 • TTY (307) 777-75648 • (307) 777-7955



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	If transported from scene to hospital:
	Name of hospital transported to
	2. Date of service
	If transported from one hospital to another hospital after patient stabiliz
	(interfacility)
	Name of hospital transported from:
	2. Name of hospital transported to:
	3. Date of service:
ital an	d Ambulance Service must fill out following information:
	d Ambulance Service must fill out following information: 3 - F-Code Cause(s) of Injury for patient:
	d Ambulance Service must fill out following information: 9 - E-Code Cause(s) of Injury for patient:
ICDS	



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Section B:	Billing Information			
Hospital:				
1.	Insurance Plan(s) Name or Program(s) Name Billed: A B C			
	Check here if patient had no insurance or other source of payment.			
2.	Total Hospital Charges Billed:\$			
3.	Total Associated Trauma Service Costs Charges:\$			
4.	Amount Collected from All Sources:\$			
5.	Amount Uncompensated:\$			
Ambulance \$	Service:			
1.	Insurance Plan(s) Name or Program(s) Name Billed: A B C			
	Check here if patient had no insurance or other source of payment.			
2.	Total Ambulance Service Charges Billed:\$			
3.	Amount Collected from All Sources:\$			
4.	Amount Uncompensated:\$			

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our for r	facility was sent to the patier	nt or their representative,	om the date the bill for services rand I further certify that the amou	unt claimed
Hos	pital Administrator/Ambulanc	e Service Director	 Date	<u>-</u>
Send completed forms to:		Wyoming Departmer Office of Emergency Attn: Uncompensate Hathaway Building, 4 Cheyenne, WY 82002	Medical Services d Trauma Funds th floor	
Sec 1. 2.	tion C: EMS Office Use C Wyoming on-line financial sy Verification of patient in EMS	ystem's (WOLFS) vendor r	number:	
	EMS Trauma Coordinator of	Representative	Date	